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PAPER

Comparison of three methods of injecting the proximal interphalangeal joint in horses

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Context

Injection of the proximal interphalangeal (PIP; pastern) joint with local anaesthetic agent may be necessary as part of lameness diagnosis in horses and arthrocentesis for analysis of synovial fluid may be required in animals with wounds in the pastern region. Perceptible effusion of the joint is rare and injection or arthrocentesis of the joint technically more demanding than for most of the other limb joints. Selection of the optimal approach is therefore important.

Three different approaches to the PIP joint have been described: dorsal midline through the common digital extensor tendon (CDE), dorsolateral (or dorsomedial) adjacent to the CDE, and palmaroproximal.

The objective of this study was to investigate the efficacy of the dorsal (midline), dorsolateral and proximal palmar approaches to the PIP joint using contrast radiography, as an aid to clinicians performing arthrocentesis or injection, especially for those with little or no prior experience of injecting this joint.

Main conclusion

If arthrocentesis or injection into the dorsal PIP pouch is to be performed then the dorsolateral approach is likely to have a higher success rate when used by inexperienced clinicians. If the palmaroproximal approach is used, a small volume of radiographic contrast agent should be included with the injection to allow subsequent radiographic monitoring of the injection location, regardless of operator experience.

Approach

Seventy-five equine distal limbs were collected from an abattoir. The limbs were clipped and the skin of the pastern region was prepared as for standard aseptic joint injection. Fifteen groups of five randomly allocated limbs were created. The operators were five veterinary students in their fifth year of study with no prior experience of joint injection. Each operator performed each of the three techniques on five limbs in a random order, determined by a simple draw before the first technique was performed.

The number of attempts required to insert the needle for each approach was recorded by observation. For all injections, 38 mm 20 gauge hypodermic needles (Kendall Monoject; Tyco Healthcare) were used. Once the needle was inserted to the satisfaction of the operator, 5 ml of iodixanol (Visipaque; Amersham Health) were injected. Subsequently, a lateromedial computed radiograph (CR) was obtained of each limb using a Gigantos x-ray generator (Siemens Aktiengesellschaft) centred on the PIP joint at a film-focus distance of 70cm and exposed at 60kV and 6mAs. The presence of contrast agent only in the joint, with no contrast agent in the digital flexor tendon sheath (DFTS), was considered confirmation of a successful injection.

Results

Levels of accuracy for the dorsal, dorsolateral and palmaroproximal approaches were 32, 48 and 36 per cent, respectively (Table 1). There was inadvertent injection of the DFTS using the palmaroproximal approach in 64 per cent

TABLE 1: Number of successful and unsuccessful needle insertions and inadvertent injections of the digital flexor tendon sheath (DFTS) in 75 equine limbs subdivided into the three described techniques

Technique	Number of successful needle insertions in 25 limbs (also expressed as % [95% exact binomial confidence interval] of attempts)	Number of unsuccessful needle insertions per limb	
		With inadvertent injection of DFTS	Without inadvertent injection of DFTS
Dorsal	8 (32 [14-54])	0	17
Dorsolateral	12 (48 [27-69])	0	13
Palmaroproximal	9 (36 [17-57])	16*	0

*Five of these attempts had contrast agent within the DFTS and the proximal interphalangeal joint so were classed as unsuccessful

of injections. The dorsolateral approach was associated with fewer needle manipulations.

Interpretation

The PIP joint was injected successfully using all three approaches. However, only the palmaroproximal approach resulted in contrast within the DFTS, and when the dorsal pouch of the joint was being injected, the dorsolateral approach required a lower mean number of needle manipulations. This is of relevance for the clinical situation, where reducing the time required and the necessity for potentially painful needle repositioning are important safety considerations for both the clinician and the patient.

A previous study comparing two approaches to the PIP joint found clear advantages to the palmaroproximal approach and did not report inadvertent injection of the tendon sheath. However, there were differences in methodology, with the previous study using dye injection and manual dissection of the joint and extracapsular tissues. We believe that contrast injection followed by radiography is a superior method of detecting extra-articular injection as dissection depends on every plane of tissue being meticulously exposed whereas any radiographic contrast is easily detected on a single radiograph. The authors suggest that the synovial fluid obtained more frequently via the palmaroproximal approach may in some instances originate not from the joint but from the sheath.

Inadvertent entry into the DFTS when injecting the PIP joint is a complication that has not been previously reported. One of the reasons for initiating the present study was a clinical case with a positive PIP joint block (using the palmaroproximal approach) where the site of pain was eventually confirmed to be necrosis of the proximal sesamoid bones. This study has shown how such a diagnostic error could occur. Accidental injection of nearby structures has been reported for other synovial injection techniques. When performing diagnostic analgesia to localise lameness in horses it is essential for diagnostic accuracy to know where local anaesthetic is being placed.

The relatively low rate of success with all three techniques is most likely a reflection of the operators' lack of experience combined with the challenging nature of injecting the PIP joint.



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Papers

Comparison of three methods of injecting the proximal interphalangeal joint in horses

L. A. B. Poore, K. L. Lambert, D. J. Shaw, M. P. Weaver

The efficacy of three methods of injecting the equine proximal interphalangeal (pastern) joint was compared using cadaver limbs. Five veterinary students without prior experience attempted to inject an aqueous radiographic contrast medium into the joint using five limbs for each technique. The number of attempts was recorded and successful injection of the joint was confirmed by the presence of intra-articular contrast on radiographic examination. Levels of accuracy for the dorsal, dorsolateral and palmaroproximal approaches were 32, 48 and 36 per cent, respectively. There was inadvertent injection of the digital flexor tendon sheath using the palmaroproximal approach in 64 per cent of injections. The dorsolateral approach was associated with fewer needle manipulations.

INJECTION of the proximal interphalangeal (pastern) joint with local anaesthetic agent may be necessary as a part of lameness diagnosis in horses, and arthrocentesis for analysis of synovial fluid may be required in animals with wounds located in the pastern region. The low-motion proximal interphalangeal joint is relatively narrow and is surrounded by dense ligaments and connective tissues (McIlwraith and Goodman 1989). Coursing over the dorsal pouch of the joint is the broad common digital extensor tendon. The palmar/plantar pouch, which extends proximally, is protected by the distal digital annular ligament, proximal attachment of the digital cushion and the deep digital flexor tendon within its sheath (Denioix 2000). Further support is provided by the medial and lateral collateral ligaments, which course obliquely in a palmaro- (plantaro-) distal direction from the distal depression and tuberosity on the first phalanx to their insertion on a similar tuberosity on the second phalanx (Ruggles 2003). The smaller axial and abaxial palmar/plantar ligaments are located just palmar (plantar) to the collateral ligaments (Nickel and others 1986, Ruggles 2003). The joint is innervated by the medial and lateral palmar (plantar) digital nerves and their dorsal branches (Sack 1975). The surrounding dense connective tissues mean perceptible effusion of the joint is rare (Miller and others 1996), and injection or arthrocentesis of the joint is technically more demanding than for most of the other limb joints (Bassage and Ross 2003). Therefore, selection of the optimal approach is important.

Three different approaches to the proximal interphalangeal joint have been described: dorsal midline through the common digital extensor tendon (Wheat and Jones 1981, Stashak 1987); dorsolateral (or dorsomedial) adjacent to the common digital extensor (Nickel and others 1986, Bassage and Ross 2003); and palmaroproximal (Miller

and others 1996). The proximopalmar (plantar) pouch is larger than the dorsal pouch (Boening 2005), suggesting that injection at this location may be more successful. Furthermore, the palmaroproximal approach was recommended following comparison with the dorsal (midline) approach using intra-articular dye injections because it was associated with fewer needle manipulations in both cadaver limbs and live horses and was more likely to result in synovial fluid at the needle hub (Miller and others 1996); however, the dorsolateral approach was not evaluated in that study.

The objective of this study was to investigate the efficacy of the dorsal (midline), dorsolateral and proximopalmar approaches to the proximal interphalangeal joint using contrast radiography, as an aid to clinicians performing arthrocentesis or injection, especially for those with little or no prior experience of injecting this joint.

Materials and methods

A total of 75 equine distal limbs were collected from an abattoir. The lameness history of the animals was unknown but none of the limbs had palpable abnormalities in the pastern region. The limbs were frozen at -20°C and subsequently thawed for 48 hours before use. The limbs were clipped and the skin of the pastern region was prepared as for standard aseptic joint injection. Fifteen groups of five randomly allocated limbs were created. During all attempts to inject the joint the limbs were held by the same assistant. The sole of the foot was parallel to the ground to mimic the weightbearing position for the dorsal and dorsolateral approaches, and the distal limb was placed in flexion for the palmaroproximal approach (Bassage and Ross 2003).

The operators were five veterinary students in their fifth year of study with no prior experience of joint injection in either live horses or cadaver limbs. Each operator performed each of the three techniques on five limbs in a random order, determined by a simple draw before the first technique was performed. All five operators were given the same briefing and written instructions with diagrams on the three injection techniques before the start of the study. In addition, each technique was demonstrated once to all operators by one of the authors (LABP) on an additional cadaver limb.

The number of attempts required to insert the needle for each approach was recorded by observation. Any redirection of the needle from the original direction of insertion was classified as a new attempt, even if the needle was not removed from the limb. The operators were permitted to make an unlimited number of attempts and were unaware of the results until the study was complete.

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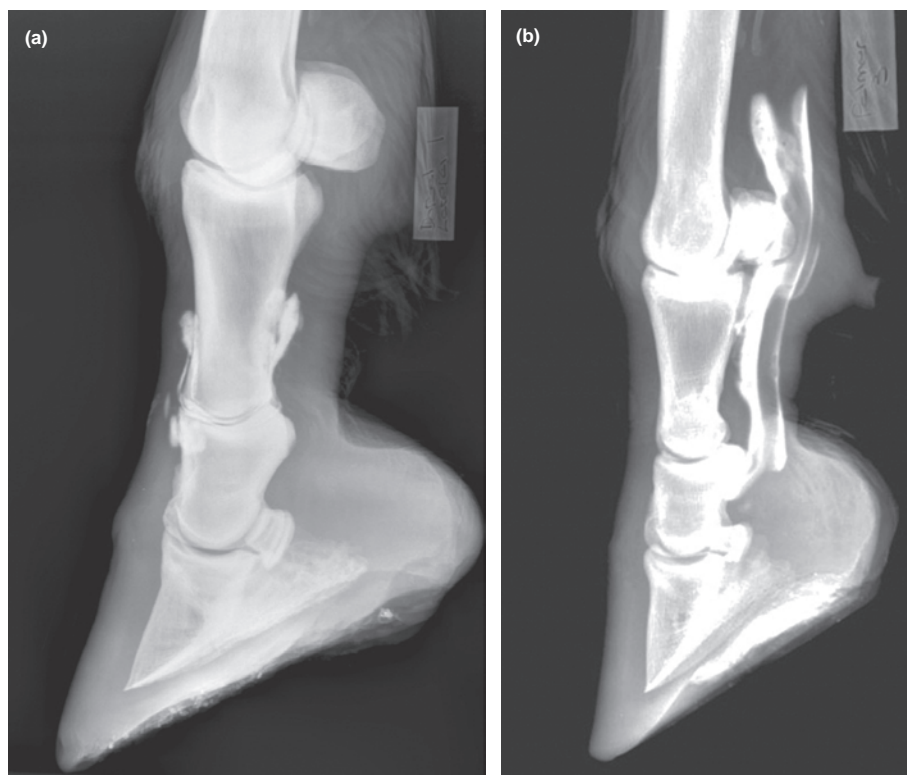


FIG 1: Lateromedial radiographic views of two cadaver distal equine limbs showing the presence of (a) contrast agent in the dorsal and palmar joint pouches following successful injection, and (b) contrast within the digital flexor tendon sheath indicating an unsuccessful injection

For the dorsal approach, the needle was inserted on the midline approximately 0.5 cm proximal to the level of the medial and lateral eminences of the proximal end of the middle phalanx. The needle was directed slightly distally and medially through the common digital extensor tendon to enter the dorsal joint pouch. To perform the dorsolateral approach, the distal lateral condylar eminence of the proximal phalanx was palpated and the needle was inserted at this level parallel to the sole and directed palmar/plantar to the edge of the common digital extensor tendon to enter the dorsal pouch. To inject the proximal interphalangeal joint using the palmaroproximal approach, the needle was inserted in a medial direction into a palpable 'V'-shaped notch formed by the palmar aspect of the proximal phalanx dorsally, the distal eminence of the proximal phalanx and the lateral branch of the superficial digital flexor tendon close to its insertion on the palmaroproximal eminence of the middle phalanx.

For all injections, 38 mm 20 gauge hypodermic needles (Kendall Monoject; Tyco Healthcare) were used. Once the needle was inserted, 5 ml iodixanol (Visipaque; Amersham Health) was injected. The needle was considered by the operator to have been inserted into the joint space if injection of the contrast agent was met with little resistance, there was visible distension of a joint pouch or fluid could be retrieved following injection. Subsequently, a lateromedial computed radiograph (CR) of each limb was obtained using a Gigantos x-ray generator (Siemens Aktiengesellschaft) centred on the proximal interphalangeal joint at a film-focus distance of 70 cm and exposed at 60 kV and 6 mA. The presence of contrast agent only in the joint (with no contrast agent in the digital flexor tendon sheath) was considered confirmation of a successful injection (Fig 1a).

Statistical analysis

The frequency of injection into the proximal interphalangeal joint for each technique was compared using generalised linear mixed-effect (GLME) models. To determine whether the number of attempts differed between approaches, GLME models with Poisson errors were used to take into account the integer nature of the 'number of attempts' dataset. For analysis of whether the correct location of contrast (yes/no) was related to the approach, GLME models with bino-

mial errors were performed. To take into account the effect of a particular operator on either successful injection or the number of attempts to inject the joint, GLME models were produced where the operator was entered as the random effect. Values of $P < 0.05$ were considered significant.

Results

No joint abnormalities were detected on any of the radiographs that could have affected injection of individual joints. In the 25 limbs used for each injection technique, the dorsal, dorsolateral and palmaroproximal approaches resulted in successful injection in eight (32 per cent), 12 (48 per cent) and nine (36 per cent) limbs, respectively (Fig 1a). The average number of attempts required to inject the joint successfully from the three approaches were seven, five and four, respectively. There were significantly fewer attempts using the dorsolateral approach compared with the dorsal approach ($P < 0.001$), but no differences between the palmaroproximal and either the dorsal or the dorsolateral approach ($P > 0.06$). There were no significant differences in the percentage of limbs with correct location of contrast, either overall between all three approaches (Table 1) ($P = 0.5$) or when only dorsal and dorsolateral approaches were compared ($P = 0.2$). In addition, there was no significant association between the number of attempts

and whether there was a successful injection ($P = 0.791$), regardless of whether only data from the dorsal and dorsolateral approaches were considered ($P = 0.859$), or if each approach was considered separately ($P > 0.050$) (Fig 2). There was also no significant interaction between the number of attempts and the approach with regard to the correct location of the contrast agent ($P = 0.079$). However, 64 per cent of the palmaroproximal injections were found to have inadvertently penetrated the digital flexor tendon sheath, whereas this did not occur with any of the dorsal or dorsolateral injections (Table 1, Fig 1b).

Discussion

In this study, the proximal interphalangeal joint could be injected successfully using all three approaches. However, only the palmaroproximal approach resulted in contrast within the digital flexor tendon sheath, and when the dorsal pouch of the joint was being injected, the dorsolateral approach required a lower mean number of needle manipulations. This is of relevance for the clinical situation, where reducing the time required and the necessity for potentially painful needle repositioning are important safety considerations for both the clinician and the horse. Both the dorsolateral and palmaroproximal approaches had more distinct anatomical landmarks for percutaneous penetration than the dorsal approach, possibly accounting for the reduced number of needle manipulations required for the dorsolateral approach, although the operators were not asked for their subjective views on which landmarks they felt were more prominent.

A previous study comparing two approaches to the proximal interphalangeal joint showed clear advantages to the palmaroproximal approach and did not report inadvertent injection of the tendon sheath (Miller and others 1996). However, there were differences in methodology, with the previous study using dye injection and manual dissection of the joint and extracapsular tissues. The authors believe that contrast injection followed by radiography is a superior method of detecting extra-articular injection, as dissection depends on every plane of tissue being meticulously exposed whereas any radiographic contrast is easily detected on a single radiograph. The authors suggest that the synovial fluid obtained more frequently through the palmaro-

TABLE 1: Number of successful and unsuccessful needle insertions and inadvertent injections of the digital flexor tendon sheath (DFTS) in 75 cadaver equine distal limbs subdivided into the three described techniques

Technique	Number of successful needle insertions in 25 limbs (also expressed as percentage [95 per cent exact binomial confidence interval] of attempts)	Number of unsuccessful needle insertions per limb	
		With inadvertent injection of DFTS	Without inadvertent injection of DFTS
Dorsal	8 (32 [14-54])	0	17
Dorsolateral	12 (48 [27-69])	0	13
Palmaroproximal	9 (36 [17-57])	16*	0

* Five of these attempts had contrast agent within the DFTS and the proximal interphalangeal joint, so were classed as unsuccessful

proximal approach may, in some instances, originate not from the joint but from the tendon sheath.

Inadvertent entry into the digital flexor tendon sheath when injecting the proximal interphalangeal joint is a complication that has not been previously reported. One of the reasons for initiating this study was a clinical case with a positive proximal interphalangeal joint block (using the palmaroproximal approach), where the site of pain was eventually confirmed to be necrosis of the proximal sesamoid bones. This study has shown how such a diagnostic error could occur. Accidental injection of nearby structures has been reported for other synovial injection techniques. Using a lateral approach to the distal interphalangeal joint in eight equine cadaver limbs resulted in radiographic contrast agent in the navicular bursa in two limbs and within the digital flexor tendon sheath in one limb, with similar results in vivo (Vazquez de Mercado and others 1998). Attempts to inject radiographic contrast into the navicular bursa of 33 feet in standing horses using two techniques (Piccot-Crézollet and others 2005) resulted in extrabursal contrast in 11 feet, including four cases with contrast within the distal interphalangeal joint. Similarly, injections of dye into the proximal palmar metacarpal region to investigate three techniques for analgesia produced distal carpal intra-articular dye at frequencies of 17 to 37 per cent, depending on technique (Ford and others 1989). When performing diagnostic analgesia to localise lameness in horses, it is essential for diagnostic accuracy to know where the local anaesthetic is being placed.

Other investigations of injection techniques have also used cadaver limbs, either exclusively (Ford and others 1989, Schramme and others 2000, Castro and others 2005) or in combination with standing horses (Miller and others 1996, Vazquez de Mercado and others 1998, Gandini 2007, Just and others 2007). Use of cadaver limbs eliminates some of the inherent variables in a study of this type, such as the temperament of live horses, which may be such that the investigation cannot be completed (Piccot-Crézollet and others 2005), or different clinical indications for arthrocentesis or injection (wounds, periarticular new bone). Also, current animal welfare legis-

lation in the UK would preclude performing this study in horses without clinical indication. Although the proximal interphalangeal joint is relatively small, the degree of joint distension is likely to be different in standing, weightbearing horses; however, the results of this cadaver study, such as the number of needle manipulations required, have direct relevance to the clinical situation with standing horses.

The use of students as operators in this study is perhaps a little more controversial. Comparable studies have used either experienced clinicians (Ford and others 1989, Dyson and Romero 1993, Schramme and

others 2000, Castro and others 2005, Piccot-Crézollet and others 2005, Gandini 2007, Just and others 2007), clinicians with no prior experience of injecting the structure under investigation (Schumacher and others 2007), students with no experience (Schramme and others 2000), a combination of students with a clinician (Gandini 2007) and some authors did not describe the prior experience of their operators (Miller and others 1996, Vazquez de Mercado and others 1998, Piccot-Crézollet and others 2005, Just and others 2007). The rationale for using inexperienced operators is that it eliminates another important variable: the level of prior experience with one of the three techniques being studied, as most experienced clinicians will favour one particular technique. It would be expected that operators with no experience would require more manipulations to achieve injection, and this was indeed the case. Depending on the technique, the operators in this study required a mean of four to seven attempts per injection, compared with mean values of 2.4 and 1.5 for cadaver injections by experienced clinicians in another study (Miller and others 1996). In contrast to the students reported here, five students injecting the navicular bursa took between 1.1 and 1.6 attempts to introduce the needle (Schramme and others 2000). One possible reason for this is that it is likely that the operators in the navicular bursa study took greater care to insert the needle, given the much greater depth of insertion using a longer needle (90 mm v 38 mm). The relatively low rate of success using all three techniques in the present study is most likely a reflection of the operators' lack of experience combined with the challenging nature of injecting this joint (Bassage and Ross 2003).

In conclusion, based on the results it is recommended that if the palmaroproximal approach is used, a small volume of radiographic contrast agent should be included with the injection to allow subsequent radiographic monitoring of the injection location, regardless of the operator's experience. If arthrocentesis or injection into the dorsal proximal interphalangeal pouch is to be performed, then the dorso-lateral approach is likely to have a higher success rate when used by inexperienced clinicians.

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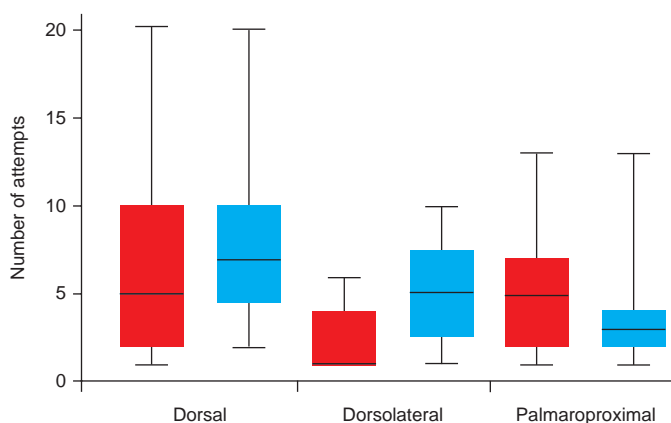


FIG 2: Boxplots of the number of attempts for successful (blue) and unsuccessful (red) injections of the proximal interphalangeal joint for each of the three techniques used in this study

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